TIMEFRAME STANDARDS FOR BENEFIT ADMINISTRATIVE INITIAL DECISIONS

Policy Number: ADMINISTRATIVE 084.14 T0 **Effective Date**: November 1, 2018

Table of Contents **Page**

Related Policies

- Disclosure Policy
- Experimental/Investigational Treatment
- Experimental/Investigational Treatment for NJ Plans

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

PURPOSE

This policy identifies Oxford's initial benefit administrative decision and notification timeframes.

This timeframe policy is based on State, Federal, Department of Labor (DOL) and National Committee for Quality Assurance (NCQA) guidelines.

DEFINITIONS

Term	Applicable State	Definition
Acceptable Phone Notification	**NY**	The health plan makes: • Phone contact with the enrollee or their designee and communicates the review time extension for, or the approval, partial approval or denial of the requested service; **and** • Phone contact with the requesting provider or provider's representative and communicates the approval, partial approval, or denial of the requested services. **OR** • Phone contact with the requesting provider or provider's representative and communicates the approval, partial approval, or denial of the requested services, and the provider has agreed to be responsible for

Term	Applicable State	Definition
		promptly notifying the enrollee of the determination. **OR** • A reasonable effort to make phone contact with the enrollee, their designee and/or the requesting provider or provider's representative, in accordance with this policy, and has not successfully confirmed notification.
Administrative Grievance/Appeal	**CT, NJ, & NY**	A request to reverse an administrative (non-clinical, non-utilization management) determination such as payment of claims, coverage of services, disenrollment or missing referrals.
Adverse Determination	**CT & NY**	A denial, reduction, termination, rescission of coverage, or failure to make payment (in whole or in part) of a benefit. **Note**: Neither the initial or subsequent processing of the claim by Oxford may be considered an Adverse Determination if the denial or failure to make payment (whole or in part) is based solely on a coding determination (i.e., assignment of diagnosis and or CPT/HCPCS or other procedure code) and the provider is a NY hospital.
	NJ	A denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, denial of a request for an in-network exception, as well as a failure to cover an item or service for which benefits are otherwise provided because Oxford determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the HMO/carrier has rescinded the coverage.
Business Day	**CT, NJ, & NY**	A working day (not including weekends or holidays).
Calendar Day	**CT, NJ, & NY**	Business and non-business days (including weekends and holidays).
Claim	**CT & NY**	Any request for service submitted by a claimant for pre-service, concurrent, or post service benefits.
	NJ	A request by a member, a participating health care provider or a nonparticipating health care provider who has received an assignment of benefits from the member, for payment relating to health care services or supplies covered under a health benefits plan issued by Oxford.
Claimant	**CT, NJ, & NY**	A covered member or the member's authorized designee.
Concurrent Review	**CT, NJ, & NY**	A review conducted during the course of treatment and concomitant with a treatment plan. Included, but not limited to, concurrent review is the anticipation and planning for post hospital needs, arrangement for post hospital or acute treatment follow-up and support, ongoing review for chiropractic, mental health services and other ongoing therapies. In New York, all concurrent care is considered urgent.
Emergent	**CT, NJ, & NY**	Sudden or unexpected onset of severe symptoms which indicate an illness or injury for which treatment may not be delayed without risking the member's life or seriously impairing the member's health.
Expedited Review	**CT, NJ, & NY**	An expedited review is a modified review process for a Claim involving urgent or emergent care.
Final Internal Adverse Determination	**NJ**	An adverse benefit determination that has been upheld by Oxford at the completion of the internal appeal process, an adverse benefit determination with respect to which Oxford has waived its right to an internal review of the appeal, an adverse benefit determination for which Oxford did not comply with the requirements of N.J.A.C. 11:24-8.4 or 8.5, and an adverse benefit determination for which the member or provider has applied for expedited external review at the same time as applying for an expedited internal appeal.

Term	Applicable State	Definition
Pre-Certification (Pre-Service) Claim	**CT & NY**	A request for services (prospective), which requires approval by Oxford before the service can be rendered; a service that must be approved in advance before it is rendered.
	NJ	Any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical.
Pre-Certification Urgent	**CT, NJ, & NY**	Requires immediate action, although it may not be a life-threatening circumstance an urgent situation could seriously jeopardize the life or health of the covered member or the ability of the member to regain maximum function or in the opinion of a physician with knowledge of the claimant's condition would subject the member to severe pain. An urgent care condition is a situation that has the potential to become an emergency in the absence of treatment.
Reasonable Effort to Notify (By Phone)	**NY**	• Two or more attempts, by phone, to advise an enrollee, or their designee, of the determination; and • Two or more attempts, by phone, to advise the provider or provider's representative of the determination. **OR** • At least two attempted phone calls to notify the provider or provider's representative of the determination where the provider has agreed to be responsible for promptly notifying the enrollee of the determination. **Note**: In each of the scenarios above, the caller must wait until someone answers the phone, the call goes to voicemail, or ten rings have occurred (in that order). If the call goes to voicemail, the caller must leave a voicemail. At least one hour must pass between calls to consider the second call a new attempt.
Retrospective, (Post-Service) Claim	**CT & NY**	A claim for services, which have already been rendered. Occurs when notification is after the fact of care/service/delivery. The need for "retro-review" is most often created by late or non-notification.
	NJ	Any claim for a benefit that is not a "pre-service claim."

POLICY

Oxford follows all State, Federal and NCQA guidelines regarding timeframes for Benefit Administrative initial determinations. In order to be compliant with all mandated timeframes, Oxford adheres to the strictest timeframe. Failure to adhere to applicable state, federal or regulatory resolution timeframes for any state in which Oxford is licensed to perform Utilization Management, may result in a technical reversal of the initial determination.

PROCEDURES AND RESPONSIBILITIES

Overview

The timeframe for initial determinations, and notification of the determinations, is calculated from the date of the request for services, or the date on which we receive all necessary information, whichever is shorter. The Department of Labor (DOL) regulations will supersede all state timeframes unless the state timeframe is more restrictive than the DOL regulations and does not prohibit application of the DOL regulations. This comparison is represented in the chart below.

Initial Determination Timeframes

Benefit/Administrative Issues

This includes, but is not limited to, items regarding problems with administrative policies, issues concerning access to providers, denials based on benefit exclusions or limitations, claims payment disputes, and administrative inquires.

NY Products Only

When conducting utilization management reviews, Oxford or its designated utilization review agent must create and retain documentation showing reasonable effort to notify enrollees, their designee, and providers of determinations, Adverse or not, by phone.

For details on what is considered a Reasonable Effort to Notify (By Phone) and for what constitutes an Acceptable Phone Notification, refer to the Definitions section for additional information.

Rescission of Authorization for CT Products

Prior authorizations for admissions, services, procedures, or extensions of hospital stays granted on or after 1/1/12 may not be reversed or rescinded if:

- Oxford failed to notify the insured or member's health care provider at least **three business days** before the scheduled date of the admission, service, procedure, or extension of stay that it was reversed or rescinded due to medical necessity, fraud, or lack of coverage; **and**
- The admission, service, procedure, or extension of stay took place in reliance on the prior authorization.

Request Type	Initial Decision Timeframe	Notification	Additional Information
Pre-Service	Fifteen (15) Calendar days from the receipt of the request	To Member, Member Designee and/or Provider by phone or in writing	• Forty-five (45) days to provide the information • Decision made within 15 days of receipt of the information or expiration of the time to provide it
Post-Service	Thirty (30) Calendar days from receipt of the request	To Member or Provider in writing	• Forty-five (45) days to provide the information • Decision made within 15 days of receipt of the information or expiration of the time to provide it
Urgent	Not later than 72 hours after the receipt of the claim	To Member, Member Designee and/or Provider by phone or in writing	• Information requested by Oxford within 24 hours of receipt of the request; 48 hours for the claimant to provide the information • Decision rendered within 48 hours of receipt of the information or expiration of the original request
Concurrent Urgent *(On-going course of treatment)* *If notification hasn't been given, default to applicable Urgent or Pre-Service	As soon as possible but not to exceed 24 hours of receipt of the request; provided that the request is made at least 24 hours prior to the expiration of the number of treatments	To Member, Member Designee and/or Provider by phone or in writing	• Information requested by Oxford within 24 hours of receipt of the request; 48 hours for the claimant to provide the information • Decision rendered within 48 hours of receipt of the information or expiration of the original request

For CT Lines of Business Only

Oxford and/or reviewer shall collect only information necessary, including pertinent clinical data, to make the benefit determination.

Adverse Benefit Determination

Notice of an adverse benefit determination must include the following (listed by product state):

Product State	Initial Decision Timeframe

CT	• Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care professional and the claim amount, if known;
	• The specific reason(s) for the Adverse Determination and a description of Oxford's standard, internal rule, guideline, protocol or other criterion, if applicable, that was used in reaching the denial;
	• If the Adverse Determination is based on medical necessity or an experimental/investigational treatment,
	  ○ A written statement of the scientific or clinical rationale used to render the decision that applies the terms of the plan to the member's medical circumstances;
	  ○ Notification of the member's right to receive, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence not previously provided regarding the Adverse Determination under review;
	• Reference to the specific health benefit plan documents, communications, information and evidence on which the determination is based;
	• A description of any additional material or information necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or

Product State	Initial Decision Timeframe
	information is necessary to perfect the request or claim; • A description of Oxford's internal appeals process; • A statement explaining the member's right to contact the State of Connecticut's Insurance Commissioner's Office or the Office of the Healthcare Advocate (OHA) at any time for free assistance with a grievance or appeal or upon completion of Oxford's internal appeals process file a civil suit in a court of competent jurisdiction. The contact information for both of these offices will be provided.
NJ	• Information sufficient to identify the claim involved, including date of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. Any request for such diagnosis and treatment information following an initial adverse benefit determination shall be responded to soon as practicable, and the request itself shall not be considered a request for a stage 1, stage 2 or stage 3 appeal; • The reason(s) for the adverse benefit determination, including denial code and corresponding meaning, as well as a description of the standard used by Oxford in the denial; • Any new or additional rationale, which was relied upon, considered or utilized, or generated by Oxford, in connection with the adverse benefit determination; **and** • Information regarding the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims, internal appeals and external appeals, which shall include the address and telephone number at N.J.A.C. 11:24-8.7(b).
NY	• The specific reason for denial, reduction or termination of services. • Reference to the plan provision relied on in making the determination. • A description of any additional information needed to complete the claim. • A description of the appeal procedures including a description on the urgent appeal process if the claim involves urgent care. • If an internal rule, guideline or protocol was used in making the determination a copy of that information, or a statement that such information will be available to members free of charge. This includes copies of criteria used in medical necessity determinations or experimental treatments.

ERISA Rights

ERISA rights apply to all commercial products except individual, church groups and municipalities. After all levels of appeals have been exhausted, the member has the right to file a civil action under 502(a) of the Employee Retirement Income Security Act (ERISA).

REFERENCES

CT Public Act 12-102.

Department of Health and Human Services §147.136.

Department of Labor Regulations 29CFR 2560.503.1.

N.J. Admin. code § 11:24-1.2

N.J. Admin. code § 11:24A-1.2

N.J. Admin. code § 11:24A-2.3

NCQA Health Plan Accreditation Standards.

NY Ins § Article 49 of the Public Health Law, 42 CFR 438

NY Senate Bill 7071, Section 4.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

11/01/2018	• Added New York plan definition of:
	  ○ Acceptable Phone Notification
	  ○ Reasonable Effort to Notify (By Phone)
	• Revised procedures and responsibilities; added language for New York products only to indicate:
	  ○ When conducting utilization management reviews, Oxford or its designated

Date	Action/Description
	utilization review agent must create and retain documentation showing reasonable effort to notify enrollees, their designee, and providers of determinations, Adverse or not, by phone ○ For details on what is considered a Reasonable Effort to Notify (By Phone) and for what constitutes an Acceptable Phone Notification, refer to the *Definitions* section [of the policy] for additional information • Updated supporting information to reflect the most current references • Archived previous policy version ADMINISTRATIVE 084.13 T0